

CHAPTER 13

SECTION 1.3

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

Issue Date: March 3, 1992

Authority: [32 CFR 199.14](#)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are allowable charge determinations to be made in the determination of reimbursement for 1992 and forward?

III. POLICY

A. On September 6, 1991, the final rule was published in the Federal Register implementing the provisions of the Defense Appropriations Act for Fiscal Year 1991, Public Law 101-511, Section 8012, which limits payments to physicians and other individual health care providers.

B. The final rule provided for the setting of TRICARE payments at the Medicare locality levels. This required a zip code to Medicare locality crosswalk to be developed, and locally-adjusted appropriate charge data be maintained by the contractor for each locality.

1. Each calendar quarter, a new zip code/Medicare locality file shall be provided to the contractors. This file shall contain all active zip codes. Nevertheless, contractors shall probably encounter zip codes that do not appear on the zip code/Medicare locality file. TMA shall inform the contractors of the Medicare locality of new zip codes. In rare instances where the contractors have not been notified of the Medicare locality for a zip code, the contractors shall be responsible for referring identified zip codes to TMA so that TMA can place the zip code in a Medicare locality.

2. The zip code/Medicare locality file will contain a 2-digit state code [both alphabetic abbreviations and Federal Information Processing System (FIPS) codes], the 5-digit zip code, and a 3-digit Medicare locality code for each zip code. The file will contain about 42,000 codes. In addition to the zip code/Medicare locality file, a listing of the

corresponding 7-digit Medicare codes and how they correspond to each of the 3-digit codes will be provided to the contractors.

3. The zip code/Medicare locality file has a file layout as follows:

DATA TYPE	COLUMNS	
State abbreviation	1-2	alphabetic
State FIPS code	3-4	numeric
Zip code	5-9	numeric
Locality	10-12	numeric

For example, the first two columns will be the State code, the third and fourth columns will be the State FIPS code, the fifth through ninth columns will be 5-digit zip code, and the 10th-12th columns will be the Medicare locality code. The most current locality for the zip code would always be in columns 10-12. Previous years localities would be in the columns next to columns 10-12 by year in descending order, newest to oldest. Eliminated zip codes shall be zero filled. The file is in ASCII format and will be provided on a 3.5" diskette.

- a. When a claim is submitted to the contractor, the contractor shall use the provider's zip code (see below) to determine the provider's Medicare locality and then access the appropriate locality-specific procedure code file. The contractor shall thus need to maintain one file for every Medicare locality in the contractor's geographic area instead of one file for each state. Medicare locality codes consist of a three-digit code.

NOTE: The provider's zip code will be the zip of his/her office practice. The contractors are to use the provider's zip code on the provider file at the time the claim is processed and not the zip code on the claim. A zip code of a P.O. Box would not be acceptable except in Puerto Rico. Anesthesiologists, radiologists and pathologists would be allowed to use the zip code of a P.O. Box (ADP Manual, Chapter 2, Section 7, Element Name: Provider Zip Code). Contractors must use the zip code of the MTF for services provided under a partnership arrangement/Resource Sharing. For hospital-based providers or providers in a teaching setting, the contractors must use the zip code of the hospital.

- b. For payment purposes, the contractor shall determine whether this calculated amount (locally-adjusted CMAC for the appropriate payment locality) is lower than the billed charge. For partnership claims or claims where the provider has agreed to take a discount from the prevailing, this reduction must be taken into consideration. Therefore, for claims involving a discount, the prevailing must be discounted then compared to the billed charge to determine the lower of the two.

4. TMA will provide the contractors with national conversion factors (CF) for most professional services (medical and surgical), adjusted to each Medicare locality. Separate CFs will be provided for medical, surgical, radiology, and pathology services for each of the Medicare localities and for each of the four classes of providers. The national CFs will be used by the contractors in pricing "by report" and "unlisted" procedures. The contractors' medical consultants are to use the Medicare RVUs as published in the Federal Register, in estimating an RVU when they apply the national conversion factors.

NOTE: The national conversion factors are not to be applied to anesthesiology, lab, DME, routine dental, Program for Persons with Disabilities, and other non-professional services such as drugs, supplies, facility charges, or ambulance services.

National conversion factors will be provided in a separate pricing file. The layout for this file is as follows:

VARIABLE	COLUMNS	DATA TYPE COMMENTS
TRICARE/CHAMPUS Locality No.	1-3	range 001-225*
Class 01 CF - Medical	4-8	
Class 01 CF - Surgical	9-13	
Class 01 CF - Radiology	14-18	
Class 01 CF - Pathology	19-23	
Class 04 CF - Medical	24-28	
Class 04 CF - Surgical	29-33	
Class 04 CF - Radiology	34-38	
Class 04 CF - Pathology	39-43	
Class 02 CF - Medical	44-48	
Class 03 CF - Medical	49-53	
<i>NOTE: * For services provided on or after January 1, 1998, the range is 301 - 389.</i>		

The file shall be on a 3.5" diskette in ASCII character data. All variables shall be zero-filled and right-adjusted. All conversion factor variables will have two implied decimal places.

C. Categories of care not subject to the National Allowable Charge System.

1. Pricing for certain categories of health care shall remain the responsibility of the contractor. The following categories will continue to be priced under current contractor procedures:

Durable Medical Equipment (DME)

Routine Dental (ADA codes)

Anesthesiology

Lab (not CMAC priced)

Ambulance

D. The following procedures which may have been separately reimbursed in the past are no longer eligible for separate TRICARE/CHAMPUS cost-sharing. Payment for these services is included in the payment for other services.

15850	Remove sutures under anes., same surgeon
20930	Allograft, morselized
20936	Autograft, same incision
22841	Internal spinal fixation
78890	Generation of automated data <= 30 min.
78891	Generation of automated data > 30 min.
90885	Psych. eval. of records, reports, tests
92340-92342	Fitting of spectacles
92352-92358	Special services for aphakia
92370-92371	Repair and refit spectacles
92531-92534	Vestibular function tests
94150	Vital Capacity, Total (Separate Procedure)
97010	Hot or cold packs
99024	Post-op follow-up visit incl. in global service
99025	Initial patient visit when minor surg. done
99050	Visit after normal office hours
99052	Visit 10pm-8am
99054	Visit on Sunday/holiday
99056	Visit outside office due to patient request
99058	Office services on emergency basis
99288	Physician direction of EMS/ALS
99358, 99359	Prolonged E&M services before/after visit
99376	Care plan oversight > 60 min

E. The CHAMPUS Maximum Allowable Charge applies to all fifty states and Puerto Rico. Guam and the Virgin Islands are to still be paid as billed for professional services.

F. Provisions which affect the TRICARE allowable charge payment methodology.

NOTE: The first CMAC file update for 1999, raises all CMACs for physicians and psychologists that are priced using the Medicare RVUs to the Medicare Fee Schedule levels. CMACs for Class III mental health providers such as social workers and counselors shall be reduced by 15 percent in 1999 and a further 10 percent in 2000 so that they will be equal to 75 percent of the CMAC for psychiatrists and psychologists by the year 2000. Medicare reimburses these providers at the same differential.

1. Reductions in maximum allowable payments to Medicare levels.

2. Balance billing limitation.

a. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. This limit is 115 percent of the TRICARE allowable charge, not to exceed the billed charge.

b. Failure by a provider to comply with this requirement is a basis for exclusion from the TRICARE program.

NOTE: When the billed amount is less than 115 percent of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit is to be applied to each line item on a claim.

EXAMPLE 1: No Other Health Insurance

Billed charge	\$500
Allowable charge	\$200
Amount billed to beneficiary	\$230
(115% of \$200)	

EXAMPLE 2: Other Health Insurance

Billed charge	\$500
Allowable charge	\$200
Amount paid by other health insurance to the beneficiary	\$200
Amount billable to beneficiary	\$230
(115% of \$200)	

NOTE: When payment is made by other health insurance, this payment does not affect the amount billable to the beneficiary by the nonparticipating provider except, when it can be determined that the other health insurance limits the amount that can be billed to the beneficiary by the provider.

c. Failure to Comply

If a nonparticipating provider fails to comply with this balance billing limitation requirement, the provider shall be subject to exclusion from the TRICARE Program as an authorized provider and may be excluded as a Medicare provider.

d. Granting of Waiver of Limitation

When requested by a TRICARE beneficiary, the contractor, on a case-by-case basis, may waive the balance billing limitation. If the beneficiary is willing to pay the

nonparticipating provider for his/her billed charges, then the waiver shall be granted. The contractor shall obtain a signed statement from the beneficiary stating that he/she is aware that the provider is billing above the 115 percent limit, however, they feel strongly about using that provider and they are willing to pay the additional money. The beneficiary shall be advised that the provider still may be excluded from the TRICARE program, if he/she is over billing other TRICARE beneficiaries and they object. The waiver is controlled by the contractor, not by the provider. The contractor is responsible for communicating the potential costs to the beneficiary if the waiver statement is signed. A decision by the contractor to waive or not to waive the limit is not subject to the appeals process.

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